

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041012</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Brighton Gardens-Prospect Heights</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>700 E. Euclid Avenue</u> <u>Prospect Heights</u> <u>60070</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(847) 797-2700</u> Fax # <u>(847) 797-2705</u>		(Type or Print Name) _____	
IDPA ID Number: <u>351947426001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>6/5/95</u>		(Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>Tracy R. Mitchell</u> <u>Partner</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Bradley & Associates, Inc. 201 S. Capitol Ave, #910</u> <u>Indianapolis, Indiana 46225</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code <u>501(c)3</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Tracy R. Mitchell</u> Telephone Number: <u>(317) 237-5500</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brighton Gardens-Prospect Heights# 0041012 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>6</u>	Skilled (SNF)	<u>6</u>	<u>2,190</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>24</u>	Intermediate (ICF)	<u>24</u>	<u>8,760</u>	3
4		Intermediate/DD			4
5	<u>128</u>	Sheltered Care (SC)	<u>128</u>	<u>46,720</u>	5
6		ICF/DD 16 or Less			6
7	<u>158</u>	TOTALS	<u>158</u>	<u>57,670</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>365</u>	<u>35</u>	<u>1,149</u>	<u>1,549</u>	8
9	SNF/PED					9
10	ICF		<u>7,984</u>		<u>7,984</u>	10
11	ICF/DD					11
12	SC		<u>30,373</u>		<u>30,373</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>365</u>	<u>38,392</u>	<u>1,149</u>	<u>39,906</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.20%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/5/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/5/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 6 and days of care provided 1,149Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/02 Fiscal Year: 12/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Brighton Gardens-Prospect Heights # 0041012 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	300,146	25,527	2,870	328,543		328,543		328,543		1
2	Food Purchase		221,680		221,680		221,680	(17,737)	203,943		2
3	Housekeeping	80,887	16,426	2,349	99,662		99,662		99,662		3
4	Laundry	19,457	7,679		27,136		27,136	(13,598)	13,538		4
5	Heat and Other Utilities			168,448	168,448		168,448	(36,177)	132,271		5
6	Maintenance	69,411	6,676	123,526	199,613		199,613		199,613		6
7	Other (specify):*	8,953		4,388	13,341		13,341		13,341		7
8	TOTAL General Services	478,854	277,988	301,581	1,058,423		1,058,423	(67,512)	990,911		8
	B. Health Care and Programs										
9	Medical Director			12,400	12,400		12,400		12,400		9
10	Nursing and Medical Records	575,145	61,188	12,082	648,415	(39,540)	608,875		608,875		10
10a	Therapy	69,644	10,032		79,676		79,676		79,676		10a
11	Activities	66,975	5,272	18,146	90,393		90,393		90,393		11
12	Social Services					38,500	38,500		38,500		12
13	Nurse Aide Training					1,040	1,040		1,040		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	711,764	76,492	42,628	830,884		830,884		830,884		16
	C. General Administration										
17	Administrative					75,000	75,000		75,000		17
18	Directors Fees										18
19	Professional Services			623,977	623,977		623,977		623,977		19
20	Dues, Fees, Subscriptions & Promotions					3,726	3,726		3,726		20
21	Clerical & General Office Expenses	223,343	21,093	201,405	445,841	(78,726)	367,115	(34,781)	332,334		21
22	Employee Benefits & Payroll Taxes			528,639	528,639		528,639		528,639		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,318	1,318		1,318	(1,318)			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			106,423	106,423		106,423		106,423		26
27	Other (specify):*			52,234	52,234		52,234	(52,234)			27
28	TOTAL General Administration	223,343	21,093	1,513,996	1,758,432		1,758,432	(88,333)	1,670,099		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,961	375,573	1,858,205	3,647,739		3,647,739	(155,845)	3,491,894		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Brighton Gardens-Prospect Heights

#0041012

Report Period Beginning:

1/1/02

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							438,486	438,486			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,282,834	1,282,834			32
33	Real Estate Taxes			207,956	207,956		207,956	(207,956)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			207,956	207,956		207,956	1,513,364	1,721,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	533,755	8,666	3,655	546,076		546,076		546,076			39
40	Barber and Beauty Shops			21,117	21,117		21,117		21,117			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							16,000	16,000			42
43	Other (specify):*			2,353	2,353		2,353		2,353			43
44	TOTAL Special Cost Centers	533,755	8,666	27,125	569,546		569,546	16,000	585,546			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,947,716	384,239	2,093,286	4,425,241		4,425,241	1,373,519	5,798,760			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(17,737)	2		4
5 Telephone, TV & Radio in Resident Rooms	(36,177)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(13,598)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Page 5A	1,441,031			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,373,519		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 1,373,519		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Brighton Gardens-Prospect Heights

ID# 0041012

Report Period Beginning: 1/1/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Travel & Seminar	\$ (1,318)	24	1
2	Marketing	(52,234)	27	2
3	Real Estate Tax	(207,956)	33	3
4	Misc Income	(34,781)	21	4
5	Provider Participation Fees	16,000	42	5
6	Depreciation	438,486	30	6
7	Interest	1,282,834	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,441,031		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brighton Gardens-Prospect Heights# 0041012

Report Period Beginning:

1/1/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17,737)	0	0	0	0	0	0	0	0	0	0	(17,737)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(13,598)	0	0	0	0	0	0	0	0	0	0	(13,598)	4
5	Heat and Other Utilities	(36,177)	0	0	0	0	0	0	0	0	0	0	(36,177)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(67,512)	0	0	0	0	0	0	0	0	0	0	(67,512)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(34,781)	0	0	0	0	0	0	0	0	0	0	(34,781)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,318)	0	0	0	0	0	0	0	0	0	0	(1,318)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(52,234)	0	0	0	0	0	0	0	0	0	0	(52,234)	27
28	TOTAL General Administration	(88,333)	0	0	0	0	0	0	0	0	0	0	(88,333)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(155,845)	0	0	0	0	0	0	0	0	0	0	(155,845)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brighton Gardens-Prospect Heights

0041012

Report Period Beginning:

1/1/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	438,486	0	0	0	0	0	0	0	0	0	0	438,486	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,282,834	0	0	0	0	0	0	0	0	0	0	1,282,834	32
33	Real Estate Taxes	(207,956)	0	0	0	0	0	0	0	0	0	0	(207,956)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,513,364	0	0	0	0	0	0	0	0	0	0	1,513,364	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	16,000	0	0	0	0	0	0	0	0	0	0	16,000	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	16,000	0	0	0	0	0	0	0	0	0	0	16,000	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	1,373,519	0	0	0	0	0	0	0	0	0	0	1,373,519	45

Facility Name & ID Number Brighton Gardens-Prospect Heights

0041012

Report Period Beginning:

1/1/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached list						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII
Related Organizations

Care Institute Group	Management Group
Care Institute Inc. - Roseville	ElderCare Facility
Care Institute Inc. - Maplewood	ElderCare Facility
Care Institute Inc. - Highland	ElderCare Facility
Care Institute Inc. - Mesa	ElderCare Facility
Care Institute Inc. - Cherry Hill	ElderCare Facility
Brighton Gardens of Burr Ridge	ElderCare Facility
Brighton Gardens of Prospect Heights	ElderCare Facility
Brighton Gardens of Austin	ElderCare Facility
Brighton Gardens of San Antonio	ElderCare Facility
Northgate Park Nursing Home	Nursing Facility
Burlington House	Nursing Facility
Regency Manor	Nursing Facility
Green Park Nursing Home	Nursing Facility

Facility Name & ID Number Brighton Gardens-Prospect Heights # 0041012 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brighton Gardens-Prospect Heights# 0041012 Report Period Beginning:1/1/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE													
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)													
	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Illinois Development		X	Construction of facility	\$125,987.00	6/1/95	\$ 16,770,000	\$ 15,423,896	6/1/25	0.0825	\$ 1,282,834	1	
2	Finance Authority											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$125,987.00		\$ 16,770,000	\$ 15,423,896			\$ 1,282,834	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 16,770,000	\$ 15,423,896			\$ 1,282,834	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

Facility Name & ID Number **Brighton Gardens-Prospect Heights**# **0041012**Report Period Beginning: **1/1/02**

Ending:

12/31/02**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2001 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1997</td><td>8</td></tr> <tr><td>1998</td><td>9</td></tr> <tr><td>1999</td><td>10</td></tr> <tr><td>2000</td><td>11</td></tr> <tr><td>2001</td><td>12</td></tr> </table>	1997	8	1998	9	1999	10	2000	11	2001	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2001 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1997	8																											
1998	9																											
1999	10																											
2000	11																											
2001	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brighton Gardens-Prospect Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041012

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A.

Square Feet:

55,249

B.

General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

2

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1995	\$ 1,799,200	1
2					2
3	TOTALS			\$ 1,799,200	3

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Brighton Gardens-Prospect Heights

0041012

Report Period Beginning:

1/1/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	158	1995	1995	\$ 11,418,480	\$ 326,242	35	\$ 326,242	\$	\$ 2,474,004
5									
6									
7									
8									
Improvement Type**									
9	AWNING	1995		9,660	276	35	276		1,955
10	SIGNAGE	1996		4,100	117	35	117		820
11	NETTING	1996		21,925	627	35	627		4,176
12	GARDEN PATH	1997		1,900	54	35	54		317
13	WELLNESS CENTER SINK	1997		2,125	61	35	61		359
14	PARKING LOT	1997		13,139	375	35	375		2,127
15	FIRE DOORS	1997		1,293	37	35	37		209
16	BRASS KICKPLATES - DOORS	1997		1,973	56	35	56		287
17	CABINETS/COUNTER	1998		1,185	34	35	34		158
18	CARPET	1998		7,920	226	35	226		1,018
19	OVERAGE	1999		727	73	10	73		279
20	CARPET	2000		1,292	129	10	129		388
21	CARPET	2000		7,428	743	10	743		1,919
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,493,147	\$ 329,050		\$ 329,050	\$	\$ 2,488,016	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,084,985	\$ 107,917	\$ 107,917	\$	10	\$ 676,715	71
72	Current Year Purchases	63,878	1,519	1,519		10	1,519	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,148,863	\$ 109,436	\$ 109,436	\$		\$ 678,234	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,441,210	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,486	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 438,486	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,166,250	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>8</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>16</u>
---	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		160		160
4	Clinical Wages (b)		320		320
5	In-House Trainer Wages (c)		560		560
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,040	\$	\$ 1,040
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,040		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10a,1	1586 hrs	\$ 30,469	
2	Licensed Speech and Language Development Therapist	10a,1	161 hrs	3,092			445	161	3,537	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,1	1879 hrs	36,083			5,198	1,879	41,281	4
5	Physician Care	-	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 69,644		\$	\$ 10,032	3,626	\$ 79,676	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 109,660	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	221,566		3
4	Supply Inventory (priced at)	7,342		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 338,568	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,799,200		13
14	Buildings, at Historical Cost	11,493,147		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,079,601		16
17	Accumulated Depreciation (book methods)	(3,166,250)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,205,698	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,544,266	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Liability</u>	313,544		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 313,544	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	15,423,896		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 15,423,896	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,737,440	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,193,174)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,544,266	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,270,475)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,270,475)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Other adjustments	(922,700)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (922,699)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,193,174)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Brighton Gardens-Prospect Heights

0041012

Report Period Beginning: 1/1/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,934,526	1
2	Discounts and Allowances for all Levels	(237,159)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,697,367	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	413,550	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 413,550	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,065	13
14	Non-Patient Meals	17,737	14
15	Telephone, Television and Radio	36,177	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,179	19
20	Radiology and X-Ray	338	20
21	Other Medical Services		21
22	Laundry	13,598	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,094	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	34,781	28
28a	Application Fees	75,057	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 109,838	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,333,849	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,058,423	31
32	Health Care	830,884	32
33	General Administration	1,758,432	33
B. Capital Expense			
34	Ownership	207,956	34
C. Ancillary Expense			
35	Special Cost Centers	569,546	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Non allowable expenses	1,908,607	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,333,848	40
41	Income before Income Taxes (line 30 minus line 40)**	1	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Brighton Gardens-Prospect Heights

0041012

Report Period Beginning: 1/1/02

Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,114	6,501	141,916	21.83	3
4	Licensed Practical Nurses	4,268	4,538	73,536	16.20	4
5	Nurse Aides & Orderlies	22,978	24,432	321,193	13.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,410	3,626	69,644	19.21	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,009	6,198	66,975	10.81	10
11	Social Service Workers	1,956	2,080	38,500	18.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,745	30,567	300,146	9.82	15
16	Dishwashers					16
17	Maintenance Workers	4,160	4,487	69,411	15.47	17
18	Housekeepers	9,617	10,147	80,887	7.97	18
19	Laundry	2,214	2,314	19,457	8.41	19
20	Administrator	1,872	2,080	75,000	36.06	20
21	Assistant Administrator					21
22	Other Administrative	8,666	9,626	148,343	15.41	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	781	868	8,953	10.31	32
33	Other(specify)	38,634	41,617	533,755	12.83	33
34	TOTAL (lines 1 - 33)	139,424	149,081	\$ 1,947,716 *	\$ 13.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	124	12,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	124	\$ 12,400		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Donna Herman-Kincheloe	Administrator	0	\$ 75,000	Workers' Compensation Insurance		\$ 9,982	IDPH License Fee		\$ 200		
				Unemployment Compensation Insurance		6,146	Advertising; Employee Recruitment				
				FICA Taxes		152,609	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		58,551	Illinois Health Care Assoc		3,526		
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*							
				Paid time off		157,779					
				Profit sharing		26,858					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 75,000				Misc benefits		116,715					
B. Administrative - Other							Less: Public Relations Expense		(
Description				Amount			Non-allowable advertising		(
				\$			Yellow page advertising		(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 528,640	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,726	
C. Professional Services						E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Mgmt Fee			\$ 623,977			\$	Out-of-State Travel		\$		
							In-State Travel				
							Seminar Expense				
							Entertainment Expense		(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 623,977		TOTAL		(agree to Sch. V, line 24, col. 8)	\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brighton Gardens-Prospect Heights	STATE OF ILLINOIS # 0041012	Report Period Beginning: 1/1/02	Ending: 12/31/02
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. \$3,526 IL Healthcare Assoc

(3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10-17 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,480 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 16,000
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 17,737

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet finalized

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? NA
Attach invoices and a summary of services for all architect and appraisal fees.